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# "Sleight of Hand" or "Selling Our Soul"? Surviving and Thriving as Critical Qualitative Health Researchers in a Positivist World

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**Key words**: qualitative health research; interdisciplinarity; mixed methods; neoliberal knowledge economy

**Abstract**: The commodification and corporatization of research within the academy, research institutes, and professional and political sectors has ignited much attention within the critical qualitative health field. Of particular concern is that the ascendance of neoliberal rationality is increasingly making critical qualitative research transgressive and difficult to practice. We reflect on this concern by deconstructing our experiences collaborating with large teams of interdisciplinary researchers. We offer interpretation of key events, interactions, processes, and existential and material consequences, and discuss lessons learned and productive strategies for working at the margins of the health sciences. We argue for the need to engage in a comprehensive resistance agenda in order for critical qualitative health researchers to not only survive but also thrive in the health field.

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## 1. Introduction

Interest in qualitative research within the health sciences/clinical health professions has been expanding in Canada and internationally (DENZIN, LINCOLN & GIARDINA, 2006; EAKIN, 2016; FLICK, 2017). There are multiple reasons cited for this in the literature, including postmodern critiques of science, growing awareness of the complexity of psycho-social dimensions of health, the need to understand how interventions work, and social scientists' interest in investigating the influence of power and discourse on healthcare practices and experiences (EAKIN, 2016; EAKIN & MYKHALOVSKIY, 2005). However, with the ideological dominance of positivism (e.g., precision, quantification, detached observation, and "non-ideological experimentation") in health research practice and evaluation (ROSSITER & ROBERTSON, 2014, p.202), qualitative research continues to be regarded as "scientifically inferior." For example, critical scholars have noted that qualitative research is accorded less funding and resources than quantitative research within academic medical/health sciences faculties, research institutes, and professional and political sectors (ALBERT, 2014; ALBERT & LABERGE, 2017; EAKIN, 2016; ROSSITER & ROBERTSON, 2014). As EAKIN has observed, this makes practicing and teaching qualitative research "transgressive" (2016, p.107). [1]

Exacerbating the devaluation of qualitative research within health sciences is the rise of the neoliberal knowledge economy (e.g., a set of ideologically driven beliefs about the nature and utility of the research process that reflect market-centered logics and other principles of classical liberalism) which has intensified the importance accorded to the economic functions of knowledge at the expense of its social functions (CHEEK, 2007a, 2007b; DENZIN et al., 2006; ROSSITER & ROBERTSON, 2014). ROSSITER and ROBERTSON suggest that this is fundamentally reshaping scientific knowledge production by valuing predictable, measurable, and commercially productive research findings and marginalizing "curiosity-driven research" (2014, p.198). Knowledge has been re-conceptualized as an application or product, and there is greater importance accorded to the economic productivity of knowledge (e.g., push for innovation) and to the measurement and quantification of knowledge products (e.g., accountability). Such marketization of knowledge has had enormous consequences for all health researchers, but especially for critical qualitative health researchers whose political and epistemological orientation (i.e., critical hermeneutic) and research processes are in opposition to such ideologies and instrumental aims. [2]

Finally, qualitative health research has also been influenced by the centralization of research funding via team-based research grants and the requirements of funding agencies that such projects are interdisciplinary and use mixed methods (EAKIN, 2016; EAKIN & MYKHALOVSKIY, 2005; HESSE-BIBER, 2016). Such research designs are considered to be more innovative or "cutting edge" because they bring together different knowledge domains (HESSE-BIBER, 2016; HOLLOWAY & TODRES, 2007). It is also assumed that there is an "inherent" synergy in these types of research configurations and designs (HESSE-BIBER, 2016, p.650). Whilst these types of opportunities have been beneficial for some researchers who have been able to align their qualitative research interests with practical clinical and health care problems with promises to improve health care, health systems, and/or health outcomes (ALBERT, PARADIS & KUPER, 2015; EAKIN & MYKHALOVSKIY, 2005; ROSSITER & ROBERSTON, 2014), they have not been without costs. Qualitative research within a mixed methods design occupies a marginal position as it is valued primarily for improving quantitative measurement efforts or outcomes of biomedical interventions and for humanizing statistical results (ALBERT et al., 2015; EAKIN, 2016; GIDDINGS & GRANT, 2007). [3]

As a consequence of this political and epistemological reshaping of health knowledge, qualitative researchers often find themselves working in potentially hostile or precarious academic and institutional spaces that compel them to work "against the grain" and engage in ongoing resistance in an effort to "survive and thrive" (EAKIN, 2016, pp.107, 111). Rising concerns about the impact of such spaces on the quality of qualitative research have prompted scholars to critically reflect on their practices within these spaces. This has highlighted the consequences of "massag[ing] our research into prescribed forms and formulas" (CHEEK, 2007a, p.61) in an effort to ensure that we do not end up "being worked over" by these spaces but work on them instead (CHEEK, 2007b, p.1052). For the most part, such reflection has focused on the writing and teaching of

qualitative research (for noted examples see EAKIN, 2016; HART, POOLE, FACEY & PARSONS, 2017), rendering what happens during the practice of "doing the work" largely an "untold" story (CHEEK, 2007a, p.46). [4]

With an interest in contributing to this untold story, our purpose here is to share some experiences of ours collaborating with positivist researchers in team-based mixed methods studies. In particular, we want to highlight how such collaborations often force us to become magicians who engage in strategic "sleight of hand" or "tricks" whereby we reveal and conceal our political and epistemological orientation and aims in an effort to find "ways to 'fit'" without sacrificing methodological power or compromising our ideologies and aims (EAKIN, 2016, p.114). Sleight of hand is a magical technique based in illusion and is used to entertain or tell a good story and sometimes also to fool; the magician misdirects viewers' attention from what is actually being done (e.g., palming a card or hiding a rabbit in a hat) so that, when the outcome of the trick is revealed (e.g., adding the palmed card to the deck to create the illusion it was already there or pulling a rabbit from a seemingly empty hat), the perception is that it is the result of magic rather than human efforts (TARR, 1976). [5]

As part of our analysis here, we will reflect on the tensions and challenges that such collaborations have produced for us, and the existential and material consequences of the strategies we adopted. Finally, we will problematize the implications of such strategies by considering whether they in fact provide us with the means to liberate ourselves "from the iron laws of [positivist] disciplinary mechanisms" (CONTU, 2008, p.365), or whether such transgressive acts simply constitute "decaf resistance, which changes very little" (p.367). [6]

## 2. Experiences From the Field

Our first experience comes from a research grant that KONTOS was awarded to explore the impact of elder-clowning on persons living with dementia in long-term residential care. KONTOS' primary interest was to explore the relational and aesthetic dimensions of elder-clowning that support engagement of residents living with dementia in a long-term care home. However, she was strongly advised by colleagues to include a means to demonstrate therapeutic benefit, and so she included a study objective to capture therapeutic impact using quantitative outcome measures. This was a move that at the time of submitting the grant did not seem to pose any significant compromise to her research interests in elder-clowning because this was an entirely separate objective. The qualitative objective was to capture the strategies and techniques of elder-clowning to better understand the factors related to the art form that influence its effectiveness and the specific characteristics of the study-setting (resident-, health care practitioner-, and organizational-level factors) that may influence elder-clowning. The quantitative objective was to capture the impact of elder-clowning on standard clinical outcome measures of neuropsychiatric symptoms and quality of life of residents living with dementia. To support the mixed methods design, KONTOS collaborated with an interdisciplinary team of qualitative and quantitative health researchers. [7]

The quantitative data analysis yielded statistically significant improvements on the chosen outcome measures, something the team was very eager to publish. However, as KONTOS began to write up the findings she found herself caught in an existential conflict. Central to her research program is a critical interrogation of the tragedy discourse of dementia, specifically the assumption that the neurological impairment that causes dementia leads to a total erasure of the self (BEHUNIAK, 2011; DAVIS, 2004; KONTOS, 2012). Within the "acute cure" model of biomedicine, the person living with dementia is reduced to his/her neuropathology (BEHUNIAK, 2011; CUIJPERS & VAN LENTE, 2015; KONTOS & GRIGOROVICH, 2018). The actions of individuals living with dementia are seen only through a lens of pathology, what Downs et al. have termed "diagnostic overshadowing" whereby "all actions and expressions are attributed to the labeled condition" (DOWNS, CLARE & MACKENZIE, 2006, p.240). Such attribution is tied to the discourse of "loss of self" with dementia, which is itself a legacy of the Enlightenment's coupling of memory, mind, and selfhood (KATZ, 2012). At the stage of writing up the quantitative findings, KONTOS reflected on the ways in which the measures themselves reproduce the discourse of pathology. For example, by not differentiating between purposeful and non-purposeful actions or emotional expression, such measures implicitly support the assumption that all of the actions and expressions of persons living with dementia are "behavioral and psychological symptoms of dementia." [8]

KONTOS considered not publishing the quantitative analysis and results as a way to resolve this tension. However, the quantitative team members strongly felt that the results should be published because their statistical significance offers compelling evidence of the effectiveness of elder-clowning that would be crucial for supporting its broader adoption. The general sentiment of their response is aptly captured in this brief e-mail correspondence: "It's not easy, and sometimes decisions we have to make in the academic sphere go against our work in the practice and real world sphere. You sometimes have to make that sacrifice to help change things." The team also believed that the quantitative findings could be published in a high impact clinical journal—something that was regarded as important for everyone's research program and career. Thus choosing not to publish the findings would go against the consensus of many of the team members, with potential consequences for future collaborations. Finally, not publishing could also negatively impact KONTOS' future funding applications since she would not have fulfilled a key objective of her grant, and subsequent grants would presumably build on this study. [9]

KONTOS decided in the end to publish the results, however a sleight of hand was needed to demonstrate coherence between her epistemological and political commitments and her use of the quantitative outcome measures. She decided to be strategic about how the results were framed and presented in the final publication—what EAKIN (2016, p.113) refers to as "discursive" strategies of resistance. Specifically, KONTOS introduced a critique of the treatment and management of behavioral and psychological symptoms of dementia, which can be found at the outset of the published paper:

> "The treatment and management of behavioral and psychological symptoms of dementia (BPSD) is associated with use of high levels of psychotropic medications, which has received national and international attention given evidence of significant harms and deleterious consequences of inappropriate psychotropic medication use" (KONTOS et al. 2016, p.347). [10]

She further added a critique of BPSD discourse since research shows that "the behavior of persons with Alzheimer's disease is not always symptomatic of dementia itself but may be need-driven or indicative of other purposeful and meaningful communication" (ibid.). [11]

Another strategy of hers was to critique the measures themselves in the limitations section:

> "Finally, although validated for this population, the measures used in this study do not reflect current understanding of BPSD in the dementia field, specifically differentiation between behaviors based on their potential cause. As a consequence, the quantitative assessment of the effect of ... elder-clowning ... was not able to discern between changes in need-driven behaviors that may be more amenable to psychosocial intervention and those with other causes that may not (e.g., pain)" (p.352). [12]

The sleight of hand was that while this was seemingly a study in which KONTOS and her team adopted the outcome measures in an uncritical way, the inclusion of the critiques of the treatment of BPSD, the BPSD discourse itself, and the outcome measures, was a deceptive strategy to create coherence with the author's epistemological and political commitments. [13]

The paper was accepted for publication in a very high-impact journal and received media attention within KONTOS' research institution (Toronto Rehabilitation Institute-University Health Network), university (University of Toronto), and beyond. She was featured in the media (television and online) about the study, and the publication was chosen to be profiled in the University Health Network's Annual Research Report (UHN, 2016), a report that profiles the research of only one scientist for each of the five research institutes that are part of the University Health Network. Given concerns about how the study would be framed by these media platforms, KONTOS felt the need for another sleight of hand. Specifically she leveraged this public interest to bring greater attention to the qualitative research component of the study. [14]

For example, although this report typically profiles only one publication per scientist, she negotiated that the report also include mention of the formative qualitative publication (KONTOS et al., 2017). She also negotiated that she be able to edit the story in the report to control the message and language. Collaborating on drafting the content included in the report is not something that is usually done; however when she indicated that it was a condition of profiling the work, the writers agreed. In particular, she was concerned that the research would be framed as a successful "therapeutic intervention" for managing

challenging dementia-related behaviors, rather than as an art form that enriches the lives of older adults living with dementia by providing them with an opportunity for creative self-expression. Despite concerns about publishing the quantitative analysis and the subsequent media attention it garnered, in the end, both afforded a unique opportunity to extend KONTOS' critique of BPSD and the consequent pathologization of dementia to a broader audience. Working within positivist spaces produces necessary and inevitable epistemic clashes or moments of dissonance that require management by qualitative researchers, specifically engaging in acts of sleight of hand. At the time this was happening, KONTOS felt she was making these decisions in the moment; the unplanned and unanticipated tension and resolution underscores the need to engage in critical reflection and planning before embarking on mixed methods research. [15]

In the next example, we have changed a number of details about the nature of the study and the research context because it is more delicate/political given the issues that we discuss. This second experience comes from a funded research grant that KONTOS was a co-Principal Investigator on. It was a mixed methods study of musculoskeletal work-related injuries in the home care sector with the objective to identify personal and environmental factors associated with the occurrence of these injuries. Data collection followed a sequential design that began with the use of a self-administered questionnaire based on validated scales, which was followed by focus group discussions with workers and employers to obtain insight into how such injuries occur and could be prevented. [16]

KONTOS was invited to participate on this grant, which involved an interdisciplinary team of health researchers, including safety science experts, epidemiologists, and numerous community partners. The study objectives had already been defined and KONTOS was invited on the basis of the need for a researcher with qualitative expertise. Aware of the dangers of being conscripted into a service or "paramedic role" (EAKIN, 2016, p.116) from both her prior experiences and her knowledge of critiques of mixed methods research (EAKIN, 2016; GIDDINGS & GRANT, 2007; GREENE, CARACELLI & GRAHAM, 1989), KONTOS strategically lobbied for the co-Principal Investigator role to ensure that she could lead the qualitative component of the study. She also invited GRIGOROVICH to join the team given her expertise in critical inquiry and her research experience in work-related injuries and in home care. Our interest in this research was to introduce a critical perspective to understanding vulnerability to workplace injuries in order to shift from the dominant emphasis on individual risk factors to a focus on the social structures that often create and perpetuate such vulnerability. This interest was initially supported by the team. [17]

KONTOS took the lead on the qualitative data analysis and the other team members expressed a strong interest in participating. While such interest is in principle a good thing, it did pose some significant challenges. In discussing our analysis with the team, the general consensus was that social scientific terms and social theory were not necessary and actually detracted from the main message. A notable example is that team members felt that the data should "speak for themselves" with analysis consisting of cataloging data into pre-conceived

conceptual categories (e.g., barriers and facilitators). Despite the lack of understanding of critical qualitative research, they nonetheless challenged our analysis, albeit couched in false humility. This is aptly captured in the following e-mail excerpt from a co-investigator: "I know there are many perils with providing advice regarding an area [qualitative analysis] in which one is nowhere close to being an expert, but regardless of the landmines, here I go ..." [18]

Perhaps the most difficult challenge we faced was that while we identified traditional avenues of prevention such as further improving safety training and management of environmental hazards, we also exposed organizations for their part in workplace injuries (e.g., an organizational ethos that requires that workers put the safety of their clients before their own). The co-investigators were more comfortable reproducing the assumption in much of the epidemiological and safety science literature that risk is inherent to an individual or population group (WEIL, 2009), or a specific organizational sector. This assumption effectively individualizes responsibility for safety by placing the blame for injury on the individual worker (HOPKINS, 2006; HOWE, 2000; TREIBER, 2009; ZOLLER, 2003). While there is some research that implicates poor working conditions or safety culture (DeJOY, 2005; TIERNEY, 1999), the co-investigators preferred to focus the analysis on blaming the individual workers; co-investigators chimed in together with "Can't you find examples of this in the data?" Thus our analysis was clearly at odds with entrenched professional beliefs and practice ideologies of our co-investigators regarding causes and prevention of work-related injuries. [19]

A further tension was that, given the role of organizations in workplace injuries, we were interested in arguing for political action and emancipation, which was perceived by the team as extending beyond the remit of our disciplines. The consensus was that we should not argue for structural remediation in order to prevent injuries "unless we feel this research belongs to political science, which might be problematic because we do not have technical expertise in this subject area." Also, co-investigators were concerned that our analysis did not translate into readily applicable/implementable recommendations regarding how injuries can be prevented. This is aptly captured in the following e-mail correspondence: "If we conclude that revolution is needed to help the worker to escape exploitation, we acknowledge that our research is worthless, because injuries are not preventable until this happens. I do not think this is the case." These comments underscore that critical hermeneutic research does not readily fit into the evaluative parameters defined and prized by the new knowledge economy, specifically evaluations that work to generalize or quantify findings for neoliberal productivity (ROSSITER & ROBERTSON, 2014). [20]

Herein lies the tension between critical hermeneutics and instrumental inquiry. Knowledge emerging from critical hermeneutic inquiry often destabilizes what we currently know about the world and how we have come to know it. In our case, we destabilized the epidemiological and safety science perspectives on the causes of workplace injuries in home care and how they can be prevented, which proved to be the very perspectives embraced by the rest of the research team. [21]

Managing these practical and ideological tensions was both demanding and difficult. Much time and energy was focused on finding a solution that would allow us to publish the analysis without compromising our commitment to critical inquiry. We decided to submit our analysis to a clinical journal, and, as a sleight of hand, we created the illusion of having removed a card from the deck (i.e., critical theory) that was actually still there. That is, we "toned down" the critical perspective by translating many of the social scientific concepts into "lay terms" to make it accessible to a clinical audience, and by softening our arguments. For example "agency/structure" became "decision-making/organizational values and managerial practices," and "the factors identified as contributing to workers' vulnerability to injury *can* be attributed to organizational values and managerial practices that prioritize efficiency at the cost of worker safety" became "...*may* be attributed." [22]

Because critical social theory still informed our analysis, we felt that this sleight of hand—what has been referred to as "a lighter version of social science" by ALBERT et al. (2015, p.21) in their study of the experiences of social science and humanities scholars—was one we could live with. However, it was not without existential angst. As a participant in ALBERT et al.'s study so aptly describes (2015, p.21):

> "Having to align [our] research practices with the medical field's doxa is difficult to swallow: I think what I feel is almost alienated from myself doing that kind of work [publishing in clinical journals]. I feel like the work I'm doing is irrelevant. What am I adding to, what am I contributing, what am I helping to develop around social thought or theory? Nothing. So I feel irrelevant, and almost empty. And it hurts, right? It's painful." [23]

Despite all of the changes we had made to the manuscript, the outcome of our submission was a rejection letter from the editors of the journal who felt that our manuscript was "too theoretical," the exploratory nature of our research was not outcomes focused, and there were no clear practice recommendations. We are not sure what in the end was more difficult, the rejection itself, or the reasons for rejection that validated the evaluative standards of positivism embraced by our team, and that perpetuated the marginalization of critical scholarship in health research. [24]

We decided that further diluting our analysis of critical theory and continuing to "butcher" the manuscript in this fashion was not an option since this would be antithetical to the political and epistemological underpinnings of critical qualitative health inquiry. We had done enough damage already with the first submission by compromising its potential to explicitly question the "givens" of the causation and prevention of workplace injuries in home care. Instead, we decided to make the theory more explicit and submit the paper to a critical social science journal. Unfortunately, and to our disappointment, our manuscript was once again rejected but this time with the explanation that it "wasn't theoretical enough." For example, one reviewer commented that "the theory appears ‘tacked on to the data,'" the analysis was "not a convincing interpretation," our findings were

"under-conceptualized/theorized," and the "posture/perspective of the paper is not sufficiently critical." [25]

In reflecting on this debacle and trying to make sense of how we as critical researchers ended up in this predicament, we realized that the pressing deadline of our end-of-grant report and pressures from the team to quickly revise and resubmit the manuscript publication left us little time to further interpret the data by engaging more deeply with the theory. We thus agree with ROSSITER and ROBERTSON that "the drive for certain kinds of accountability and rationalization of knowledge and knowledge production severely limits" critical hermeneutic inquiry (2014, p.211). This suggests that neoliberal practices of control and domination were deeply implicated in our double failure given how they prematurely truncated the creative space needed to support more reflexive and critical theoretical engagement. [26]

With perseverance, we were successful in publishing our paper in a clinical journal that has a special focus on the social determinants of health. Reviewers' reports were very positive: "The authors are to be congratulated, as their theoretically-driven analysis makes an important contribution to safety science." However, this experience has prompted us to think deeply about our sleight of hand strategies and the ways in which we are not only "playing the politics of the system" (CHEEK, 2007a, p.62), but also how the system is "playing us." [27]

## 3. Discussion and Conclusions

Academic medical/health sciences faculties and research institutes are hierarchical organizations with a positivist social order that is maintained through structural mechanisms (e.g., standardized evaluation criteria and explicit practice expectations). Qualitative health researchers who work in these spaces face cultural dissonance given how the neoliberal knowledge economy creates a marked imbalance between research that is socially legitimated (both instrumental and biomedical) and research that is not. With such imbalance, when qualitative researchers enter interdisciplinary collaborations in the context of mixed methods studies, tensions abound. [28]

Scholars who have written about such challenges have suggested that despite this cultural dissonance, it is possible not only to survive but also thrive by resisting the epistemic pressure to conform to the practice and standards of positivism. For example, discussing the challenges of teaching qualitative research, EAKIN suggests that we develop "a new stance towards dancing with the devil" by dropping our defensive stance and by refusing to be put in a service position (2016, p.117). The specific strategies that she identifies to achieve this are: creating a supportive organizational base; developing strategic curricular content; and building a strong community of practice. Others have similarly noted the importance of communication-based resistance strategies. For example, HART et al. (2017) note the importance of "holding firm" and "pushing back" by reaffirming the underlying assumptions of critical qualitative research and challenging the language of positivist science that prevails in academic and

clinical health research contexts. In the context of the study on elder-clowning, KONTOS' discursive strategies of resistance were consistent with what EAKIN describes as "strategic curricular content" (2016, p.111). However, it may be that these strategies were successful in that case because she was able to articulate a critical stance without threatening the entrenched professional beliefs and practices of her team members. KONTOS' expertise as a critical qualitative health researcher was also trusted and respected on that team, which gave her the space to analyze and write up the qualitative data without challenge from other team members regarding the fundamentals of hermeneutic inquiry, as was experienced in the home care study. [29]

HESSE-BIBER (2016) argues that researchers working in interdisciplinary realms must demonstrate a range of relational skills that foster interdisciplinary engagement. She specifically focuses on communication strategies including actively listening to others without interrupting, and being respectful of others' contributions. However, citing relational skills as the key to interdisciplinary team relationships seems to miss the incommensurability of philosophical assumptions held by different team members. In our experience, the challenges well exceeded communication difficulties given that they are rooted in ideologically driven beliefs about the nature and utility of critical qualitative research. Perhaps it is because of such incommensurability that in mixed methods research there is very little integration of qualitative and quantitative research findings. A review of mixed methods studies reveals that many such projects remain "unmixed" with the noted practice of publishing parallel quantitative and qualitative components (O'CATHAIN, MURPHY & NICHOLL, 2008). In the absence of integration, "methodological pluralism" seems a more accurate term than "mixed methods," and applies better in our examples as well. [30]

ROSSITER and ROBERTSON (2014) take a different approach to how critical qualitative health researchers can manage these challenges. They suggest that a paradigmatic shift is needed away from the qualitative/quantitative divide towards a re-categorization that accounts for increased demand for knowledge that is outcome driven, with predictable results that are measurable and amenable to economic rationalization. This shift is precisely what they maintain will provide the means for qualitative researchers to navigate their own political/epistemological positions and thus make "choices" regarding the direction of their own research agendas. We agree that such understanding is a pre-condition for resisting the demands of the neoliberal knowledge economy. However, to conclude with choice being the action that results from such understanding leaves unaddressed the layers of political action and activism that CHEEK (2007b) describes as necessary to address both the tensions operating within the field of research as well as the forces or tensions operating on that field from without. It is our contention that, without activism, we will continue to find ourselves "worked over" by the spaces we practice in. Collective and systematic action is critical, otherwise we run the risk of remaining on the surface and playing the politics of the system rather than changing its politics (ibid.). [31]

Critical organizational scholars have suggested that discursive strategies of resistance offer us a false sense of micro emancipation because they fail to dismantle broader "disciplinary mechanisms" (CONTU, 2008, p.365). CONTU terms this "decaf resistance," which creates the illusion of resistance without the costs associated with making real structural changes. She goes on to argue that such resistance also reproduces the neoliberal social order that the resistance itself purports to challenge. She defines decaf resistance as "resistance without the acid that can destroy the machine of power" (p.374). LATHER (2016) similarly argues that despite "earnest advocacy" such efforts often lead to "over-claims to make a difference" (p.125). [32]

We thus contend that, for qualitative health researchers to thrive, their micro resistance efforts must be complemented with radical macro emancipation. A framework for such a comprehensive agenda of resistance has been proposed by DENZIN (2017) in a recent special issue of *Qualitative Inquiry* on the "Challenges for a New Critical Qualitative Inquiry." Here he argues for a three-pronged strategy that entails intellectual, advocacy, and operational forms of resistance to the neoliberal knowledge economy. The intellectual refers to the need for international, national, and local level platforms that encourage critical interrogation of the focus on commercial ends-oriented research and the myriad other ways that neoliberal rationality marginalizes critical inquiry. Examples of such platforms include the International Congress of Qualitative Inquiry and the international In Sickness and In Health conferences, each of which have forged global communities of practice to engage critically in key debates about critical inquiry, scientific knowledge, and health research. [33]

The advocacy agenda refers to forging strategic and tactical alliances with policy figures, media, publishers, and funding bodies in order to effect shared governance of science. For example, ALBERT and LABERGE (2017) have argued that immediate measures should be taken in Canada to achieve greater participation of qualitative researchers in the leadership of the Canadian Institutes of Health Research (CIHR), which is our national funder of health research. This would ensure that the CIHR College of Reviewers consists of academics with relevant expertise in the core methodologies and theoretical orientations of qualitative inquiry. Finally, the operational agenda calls for all qualitative researchers to themselves engage in micro level resistance efforts by building individual capacity via affiliation with professional associations, journal editorial boards, and review panels of funding agencies, as well as collaborations across academic organizations. [34]

Over the past two decades, critical qualitative inquiry scholars have made great strides in questioning norms of objectivity, emphasizing the complexity of social phenomena, and qualifying inquiry as "a moral as well as a scientific process" (DENZIN, 2017, p.13). Such strides have been foundational to the interrogation of structural inequalities and social conditions that foster "inequality, poverty, human oppression, and injustice" (p.8). We reinforce DENZIN's argument that there has never been a greater need for social justice, and thus, at a time when critical health research is increasingly proscribed by market values, it is imperative that

we collectively resist neoliberal accountability metrics (e.g., teaching evaluations, impact factors for journals, and research funding scores) and their consequent subversion of critical knowledge production. These are the stakes for critical qualitative health research in the neoliberal public sphere. We need to build on existing inquiry that has been critical of the very structures that are reorganizing the production, evaluation, and dissemination of knowledge (ALBERT & LABERGE, 2017; ALBERT et al., 2015; CHEEK, 2007b; DENZIN et al., 2006; EAKIN, 2016; ROSSITER & ROBERTSON, 2014). It is our contention that a comprehensive resistance agenda is what is needed; it is time to resist and forge the interpretive space to pursue transformative inquiries. The Centre for Critical Qualitative Health Research of which we are academic fellows, is already making strides with such an agenda. It is an interdisciplinary teaching and research hub based at the University of Toronto that gives its fellows "visibility, legitimacy, and institutional authority" (EAKIN, 2016, p.114) in the university, affiliated research institutes, and in other research settings in Canada and internationally. In its efforts to build local, national and international capacity in critical, theoretically-informed qualitative health research and scholarship, and promote methodological innovation and critical reflection, it provides a vibrant community of practice for its fellows to collectively engage in multiscalar efforts to "hold firm, push back, and push forward" (HART et al., 2017, p.1768). There are other notable examples of collective mobilization and resistance by critical qualitative researchers (GRAHAM et al., 2011; GREENHALGH et al., 2016). It is our hope that still others will similarly embrace the call for challenging the practices and political processes that are truncating the methodological power of critical qualitative inquiry. Thriving, rather than merely surviving as critical qualitative health researchers in a positivist world depends on it. [35]

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